The Repetition & Avoidance Quarterly

Volume Eight, Number Three **The Washington State Veterans PTSD Program** **Winter 2003-2004**

Resilience to Extreme Stress vs. Vulnerability to PTSD

Reviewed by Emmett Early

Dennis Charney, M.D., of the National Institute of Mental Health reviewed the "Psychobiological Mechanisms of Resilience and Vulnerability" in a lead article in the February *American Journal of Psychiatry* [2004, 161(2), 195-216]. Using the concept of allostatic load, he examined the systems that are the basis for psychological adaptation to extreme stress. He defined "allostatic load" as "the burden born by a brain and body adapting to challenges, both physiological and psychological. The concepts of allostasis and allostatic load link the protective and survival values of the acute response to stress to the adverse consequences that result if the acute response persists" (p. 195). He states that his article is an attempt "to identify a putative neurochemical profile that characterizes psychobiological resilience and has predictive value regarding successful adaptation to extreme stress" (p. 196).

See other articles addressing the topics of resilience and vulnerability to psychological trauma on pages 6 and 9.

Dr. Charney then proceeds to take the reader through various key neuro-biological systems that are involved in adaptation to stress. Here the article becomes difficult for those of us not well versed in neuroanatomy. He reviews the latest research involving the adrenal steroid cortisol and corticotropin-releasing hormone (CRH). He points out the deliterious effects of excessive and sustained cortisol secretion, such as "hypertension, osteoporosis, immunosuppression, insulin resistance, dyslipidemia, dyscoagulation, and, ultimately, atherosclerosis and cardiovascular disease" (p. 196).

The author examins CRH in detail and observes that "early-life stress can produce long-term elevation of brain CRH activity and that individual response to heightened CRH function may depend upon the social environment, past trauma history, and behavioral dominance.… Persistent elevation of hypothalamic and extra-hypothalamic CRH contributes mightily to the psycho-biological allostatic load. Increased CSF levels of CRH have been linked to PTSD and major depression.... Psychobiological resilience may be related to an ability to restrain the initial CRH response to acute stress" (pp. 196-7).

Dr. Charney then looks at the role of epinephrine and the locus coeruleus. "The ability of acute stress to coactivate the HPA and locus coeruleus-norepinephrine systems facilitates the encoding and relay of aversively charged emotional memories, beginning at the amygdala. The amygdala also inhibits the prefrontal cortex (such as the locus coeruleus) and stimulates hypothalamic CRH release and brainstem autonomic centers, resulting in increased activity of the HPA and locus coeruleus. These feedback loops among the prefrontal cortex, amygdala, hypothalamus, and brainstem noradrenergic neurons contain the elements for a sustained and powerful stress response.... If unchecked, persistent hyperresponsiveness of the locus coeruleus-norepinephrine system will contribute to chronic anxiety, fear, intrusive memories, and an increased risk of hypertension and cardiovascular disease" (p. 197).

The author then goes into a detailed discussion of various neurotransmitters and neuropeptides, including galanin, dopamine, and serotonin. He discusses benzodiazepine receptors and the role of gonadal steroids, such as testosterone and estrogen. He provides a summary table depicting the role of each involvement in the body's adaptation to stress. He observes testosterone deminishes following activities involving extreme stress and that "women appear to be more sensitive to the effects of traumatic stress. One survey found that 31% of women and 19% of men develop PTSD when exposed to major trauma..." (p. 202). He emphasises the theme of all systems working together. "It is possible that phychobiological allostatic load will relate to vulnerability to the effects of chronic, mild, intermittent stressors, as well as extreme psychological trauma" (p. 203).

(Continued on page 10 , see *Adaptation*)

Senator Cantwell Urges Speed Up of VA Services to Eastern Washington Veterans

Washington Senator Maria Cantwell wrote in a letter to the Dr. Les Burger, Director of Veterans Integrated Service Network 20, which includes federal Department of Veterans Affairs hospitals and other health care facilities in Walla Walla and Spokane, "I am writing to ask you to ensure that sufficient funding is provided for veterans in Washington state, particularly in those areas with excessive backlogs, including Central and Eastern Washington. I am hopeful that [this year's] funding increase can be used to reduce such backlogs and insure equitable access to care for all veterans in Washington State." Senator Cantwell noted in her letter that Washington state was to receive some 30 million dollars in additional funding for the VA. She noted to Dr. Burger that at the time of her visit to Spokane "there were about 2,800 veterans on the waiting list at the Spokane VA Medical Center and hundreds more awaiting access to primary care at the Walla Walla facility. I understand the current backlog to be about 2,400 veterans in Spokane and 990 veterans in Walla Walla." Senator Cantwell concluded her letter with praise for military veterans. "I know that you share my belief that our veterans are one of the greatest assets of this country and we have a duty to ensure that they are provided benefits and assistance that they so greatly deserve." ##

WDVA Joins Federal VA in Prazosin Research Project for Returning Iraq War Vets

An undated "Dear Returning Servicemember" letter announced the research project at VA Puget Sound Health Care System. The letter welcoming the veterans home from Iraq is co-signed by Tom Schumacher, Murray Raskind, MD of the VA, and Michele Klevens, a VA "Research Health Science Specialist" and telephone contact for the project. It advises the veterans that nightmares and other forms of distressing dreams related to stressful combat situations are a "frequent occurrence." It warns that such symptoms could become chronic and gives a bit of the history of the discovery that Prazosin, a blood pressure and prostate medication, also blocks excessive adrenalin, and therefore blocks nightmares, while not interfering with normal dreaming sleep. The letter then asks for volunteers to participate in a double blind study, from which finally all veteran volunteers would receive Prazosin. It then gives Michele Klevens' phone number as the study coordinator 206 277 5088 and insures respect for privacy. ##

Everett Psychiatrist Bill Bunselmeyer Retires

Bill Bunselmeyer, M.D., psychiatric consultant for Akers Counseling in Everett, is retiring from medical practice this Spring. I first met Bill in 1978 when I was a post-doc intern at Mental Health Services in Everett. We formed a kind of journal club with a psychiatric nurse and a social worker. I remember being struck by Bill's down-to-earth style, his irreverent humor, and his delight in philosophical issues. Bill used his intellect in discussions the way he played poker, raising the bet for the fun of it.

In the mid-1980s, shortly after the first meeting of the then Society for Traumatic Stress studies in Atlanta, Bill organized the first and then second Annual Sol Duc Trauma Conference at Sol Duc Hot Springs. He reserved space in early May before the resort grew busy. The agendas for those meetings have since become rare collectors items. Bill made the keynote address that first year, presenting his thesis on how Freud was traumatized when he botched the nose operation on his patient and she hemorrhaged and nearly died. He traced the post-traumatic symptoms in Freud's subsequent writings. I can also recall Bill running, his body steaming in the cold air, from the hot pool to the cold pool at Sol Duc, whooping as if he were jumping out of an airplane.

Bill had a natural way of relating to his patients. He was himself a Vietnam combat veteran and in the latter part of his professional career used his Airedale, Sam, as his co-therapist. Bill had been an army Special Force's medic in the very early part of the war, when they were teaching farm techniques to the villagers. He went to medical school after his tour. He is the sort of man one could sit comfortably with and discuss raising hogs or his thoughts about utopia. He was raised himself on a farm in Central Illinois and dreamed of starting a treatment farm for psychotic patients.

We'll all miss having Bill to refer clients to at Aker's Counseling and we wish him a long, happy retirement. EE #

Bill Bunselmeyer, M.D., left, giving his keynote address, without power point, to an enthralled audience at the first Annual Sol Duc Trauma Conference.

VA Care in Eastern Washington Needs Restructuring

By Tim Hermson

In the region served by Walla Walla VA Hospital and its outreach clinic in Richland, as of last week there have been 990 veterans on a waiting list to enroll for VA medical care. Spokane had several thousand waiting, but, as of last week, veterans in Moses Lake report that Spokane has gone over to a "first-come, first-served—no waiting policy." I have seen numerous men stymied by "Category 8" letters denying them enrollment and not giving them any recourse or time to reapply. This problem inhibits them from agreeing to enter the crisis care for PTSD at 7 West, Seattle VAMC, that I have recommended to them. Inability to pay and mistrust of the timeliness of resolving their pending C&P claims make a barrier to service they fear to cross. There is a gap here that needs addressing by the VA.

Inconsistent Care

I have often dealt with problems of veterans returning to this region from care in Seattle VAMC only to find that the Walla Walla pharmacy will not allow them access to the same medications they were stabilized and discharged on. They have reported that the local providers tell them it is a budgetary limitation in the local VA hospital. The veterans don't understand this in view of the fact that both facilities are in the same VISN and should have consistent care and should have better communication between medical staffs for coordination of care. I spend a lot of the State's treatment time ventilating and overcoming these frustrations for my clients. The most recent complaint of this nature came out in group last night. A service-connected veteran returned from his second treatment at 7-West. He was told by his discharging physician that the doctor would arrange for his psychiatric and blood pressure medication renewals at the Richland Clinic. On reporting there (out of meds), the vet was sent away, being told he was not enrolled and could not be so for months. The vet contacted his 7-West MD and had the prescription refilled by the Seattle pharmacy. However, the pharmacy informed him it would be "seven to ten days" before it would arrive in the mail. The veteran is now without meds and has no other insurance.

During the same group session I was informed by the veterans that there is a growing duration in setting appointments for med management at Walla Walla. Very volatile and unstable vets call their doctors for side-effect and dosage problems, and they are scoffed at as there are few who can report ever reaching a doctor or having messages returned. The veterans report that only walk-ins get help.

Another quality of care concern for veterans is the reduction in access to psychiatric beds for stabilization and treatment within the geographic areas where their social support/ families reside. When Spokane eliminated their psych beds, reassuring their population that they'd be referred to Western State or St. Mary's Hospitals, they seemingly did not know that 300 beds had been closed by those institutions in the prior month. Walla Walla's nine beds (two for psych, one of which is supposed to be for females, and seven for drug/ETOH) are all that remain for veterans in the whole region of eastern Washington, eastern Oregon, and Idaho. Local civilian doctors at Kennewick urgent care centers over the last month have shared with me their dismay that they are having to prescribe psychiatric meds for over 60 days to stabilize patients they have referred to voluntary admission beds at Our Lady of Lourdes Behavioral Health Center—the only psych hospital in the region. Which is a "for profit" institution now. This bodes not well for VA referrals to local in-patient care for timely stabilizations.

Fee Services Needed

Much of the recent stress on the VA staff and the cynical stoicism in the veterans might be alleviated by utilizing the fee-basis system in place in the Puget Sound Health Care System of the VA. This could also limit the serious driving/weather impairments to accessing services that are faced east of the Cascades in both the Walla Walla and the western edge of the Spokane catchments. Spokane does occasionally fee-service some vets to Moses Lake and Ephrata. Walla Walla has maintained a policy of denying fee-basis care except for dental services.

Many veterans have informed me of their preference for local care versus travel to Spokane or Seattle for ongoing treatment. Persons with PTSD, in particular, are resistant to travel much outside the comfort zones they have found in our rural and small town regions. Their anxiety and attention deficits increase risks in long vehicle travel in bad weather and on rural roads. Many, due to their conditions, are not able to avail themselves of the few van services available in the areas. Further, many are disgruntled at the perceived inconsistencies and unexplained rationale in the VA travel reimbursement system they encounter. The offset for the "emergency and ambulance fund" confuses them. They suspect graft and fear retaliation if they complain or question. Incidents reported to me include the campus police escorting them off the VA campus for asking to see the regulations or asking to talk to a supervisor about how their income level limited their reimbursement. Local veterans feel they will bear the costs of transportation to access health care when services are reduced in this region.

I am most concerned about the quality of care issue of prolonged durations between appointments for medication management. I feel that access to in-patient care is at a poor level now and will deteriorate under the impact of CARES. I observe poor coordination of care between VA treatment facilities with Richland Clinic and Walla Walla. Patient lives are at risk. I believe staff fatigue and overloading is at a dangerous level and continues to deteriorate. Relief by fee-service referrals is not being utilized adequately for the veterans or the staff's well being. ##

Tim Hermson, MS, LMHC is the WDVA PTSD Contractor for TriCities and Moses Lake, WA.

Two Outcome Studies Underscore the Success of the PTSD Program

By Tom Schumacher

The King County Study

Client samples drawn from the King County funded PTSD Program and from the state-wide WDVA PTSD Program, have yielded impressive results. The King County PTSD Program research effort is an ongoing, repeat-measures design study now entering the fourth year of data collection. Ninety-one veteran and family member clients assessed at intake, and reassessed at three- or six-month intervals, or when possible at the time of termination of treatment, make up the working pool of subjects. The *OQ-45.2*, a 45 item, standardized mental health outcome measure, offers multiple indexes of client change. Using a Likert response format, three significant areas of interest can be assessed. These areas include Mental Health Symptoms, Interpersonal Functioning, and Social Role Engagement. A Total Inventory score can also be derived. Changes in these inventory scales scores (rising scores indicate loss of function), and shifts in clinician assigned *GAF* (Global Assessment of Function) scores over time, allow for evaluation of changes that are occurring within individual clients. Examining group data allows for an assessment by means of *t* tests of overall effectiveness of the PTSD contract services offered.

The most recent period of survey was from January 1st through December 31, 2003, although substantial *OQ-45.2* intake or baseline data were collected in the previous year. Intake data create the baseline for future comparisons of the subsequent OQ-45.2 measures. All subsequent surveys offer short term snapshot comparisons as well, wherein fairly recent changes in clients can be assessed. Data were deleted for measures missing within a given client's serial assessments. This left n = 91 active and complete subject comparisons having the full array of data, and represent the basis for the current results. Of that number, 61 subjects were veterans, and 30 family members.

The short summary of the findings indicate that all subscales demonstrated improvement when examined as a group. The *t* tests of group means showed improvement over intake (baseline) group means on all measures, including *GAF* scores. There was an interesting twist to the findings, with the advent of the military invasion of Iraq, demonstrating statistically significant increases in the Mental Health Symptoms subscale among both veterans and spouses. This effect was to later respond favorably to continued treatment, and appears to support the importance of staying in group and individual therapy during times of crisis.

When a case by case assessment of clients was performed, there was clear evidence that some clients were impacted by the war events more than others. Six of 61 combat veterans in the survey demonstrated a continued decrease in functioning in all areas, including GAF scores. However, the salient aspect of this discovery is that these clients did remain in treatment, rather than retreating from support during times of crisis. This is perhaps a strong indication of the treatment and psychoeducation related mitigation of the flight response commonly seen in PTSD suffers.

The WDVA Study

The second survey was preformed by randomly selecting 423 "nameless" client records from our intake data files. These were in all cases veterans who are or were in treatment over the past one to four years (11 to 48 months), with an average of 24.3 months in treatment. The actual curve however was bimodal, reflecting the stacking up of long term treatment among those with chronic and severe PTSD conditions.

Contract clinicians were asked to update the status of each client (identified by client number only), and to record specified outcomes for each client by offering a coded response. Since this was a cost-benefit and a clinical outcome survey effort, an array of information was requested: Changes in GAF scores from the time of intake to the present, as well as similarly framed changes in PTSD service connection, physical (medical) service connection, social security disability, employment status, volunteering, roles played within family/ community, level of social connection, and current treatment status. The survey also required responses regarding the current source of treatment funding including, *Pro Bono* hours, WDVA funding, other state sources, federal sources, private pay, and private insurance.

The results were very gratifying in that mean comparisons demonstrated significant *t* test changes in GAF scores from time of intake and subsequent reassessment. Significant shifts in the level of service connections were also found. Employment was found among 33% of the entire sample. This included part and full time employment, with many returning to some form of work. Another 22% volunteered regularly at some activity within the community.

Finally, the sources of treatment fiscal support indicate the fact that the WDVA PTSD Program continues to be a treatment entry point for many veterans around the state. The informal, private practice setting of most contractor offices, creates a less formidable first access point for mental health services. Once veterans find benefit from treatment, many apply for service connected disability as a means to fuller health care from the various VA Medical Centers. This ultimately allows the veteran access to additional mental health and medical treatment support.

The survey results support the use of state resources directed at the improvement of the lives of Washington State's many war affected veterans. Additionally, our ever-evolving connections with the VA Medical Centers and Vet Centers, means that veterans receive the best available treatment services that our combined efforts can muster. This professional partnership is especially strong in Western Washington, while in Eastern Washington services continue to suffer from a lack of mental health care for veterans needing acute and long term support.

These service delivery problems currently place a disproportionate responsibility upon our state providers and our limited resources. There remains the hope that one day the *RAQ* can report resolution of these problems of service shortages, and we are happy that at least one US Senator has her eye on these problems. (See "Senator Cantwell…" page 2) ##

Reviewer Attacks Psych Associations for Pandering to Repressed Memory Advocates

Frederick Crews, a professor of English at UC Berkeley, wrote a review of books on the repressed memory issue ["The Trauma Trap, *New York Review of Books*, 03/11/04, 37-40] in which he attacked the professional organizations of psychology and psychiatry. He reviewed Richard McNally's *Remembering Trauma*, and in the process took issue with mental health professionals who believe that multiple traumas can be repressed for long periods of time and then recalled later, usually in therapy. Mr. Crews' main complaint is with the American Psychological Association for failing to take a clear stand on the issue. He mocks the association's decision: "Recovered memory thus gets the same free pass from the APA as 'attachment therapy,' 'therapeutic touch,' 'eye movement desensitization and reprocessing,' 'facilitated communication,' and the hypnotic debriefing of reincarnated princesses and UFO abductees" (p. 39).

The professor concludes his article with the requisite zinger: "Attention to the chimerical task of divining a patient's early traumas is attention subtracted from sensible help in the here and now. The reason why psychotherapists ought to familiarize themselves with actual knowledge about the working of memory, and why their professional societies should stop waffling and promulgating misinformation about it, is not that good science guarantees good therapy; it is simply that pseudoscience inevitably leads to harm" (p. 40).

Dr. Crews, however, seems to have chimeras of his own in the works. He reveals a rather shallow knowledge of memory, especially non-cognitive memory of the sort likely to occur before the hippocampus is developed. He writes, "Likewise, it has never been established and it seems quite unbelievable, that people can be haunted by memories that were never cognitively registered as such" (p. 40).

Most disturbing of all is that Dr. Crews manages to drag in PTSD as a cultural fad promulgated by political liberals. "...the standing of post-traumatic stress dsiorder as an inetegral and historically invariable malady is now in doubt. The question is sensitive, because nobody wants to impugn the anguish of mentally impaired battle veterans. But as McNally indicates with reference to several recent studies, PTSD, like Victorian hysteria and like recovered memory itself, has begun to look like an artifact of its era—a sociopolitical invention of the post-Vietnam years, meant to replace 'shell shock' and 'combat fatigue' with an enduring affliction that would tacitly indict war itself as a psychological pathogen. However crippling the symptoms associated with it may be for many individuals, the PTSD diagnosis itself has proved to be a modern contagion" (p. 40).

Dr. Crews goes on to indict PTSD by noting the malingerers use it for their gain. "Once certified by the American Psychiatric Association as natural and beyond the sufferer's control, post-traumatic stress disorder began attracting claimants, both civilian and military, who schooled themselves in its listed symptoms and forged a new identity around remaining uncured" (p. 40).

The linking that Mr. Crews attempts of PTSD with the recovered memory scandals does the disorder a huge disservice, but also seems to be an argument that mental health practitioners should be getting used to. PTSD is a cultural phenominon not only because of its symptoms, but also because of its etiology. Child abuse, war, rape, and disaster are certainly not exclusive to any culture or era, but represent the most vulgar and primitive aspects of human life. PTSD did replace hysteria as a disorder of traumatic origin and thereby picked up up some of the oppobrium of overreactive affect and sensational claims. The fact that we are seeing priests, coaches, teachers, and scout leaders being revealed as pedophiles is most distasteful and usually sensational, but does nothing to reflect on the legitimacy of the psychological problems such crimes leave in their wakes. And it is a jaw-dropping statement to suggest that war is *not* a psychological pathogen, but a statement not unheard of in the classroom. EE ##

Ron Lowell, MSW, Takes Over Seattle Vets Group

The only Seattle psychotherapy group for veterans that is not sponsored by the federal VA, is now being led by Ron Lowell, a social worker with the VA addictions treatment center. Ron recieved his MSW from the University of Washington. Besides his addictions treatment work, Ron is a laison between incarcerated veterans and the VA in Snohomish, King, and Pierce Counties. Ron was formerly co-therapist in the ongoing veterans group and has taken over the helm from Rico Swain for 2004. ##

RAQ Retort

The *Journal of Traumatic Stress* doesn't invite comment, but we do. If you find that you have something to add to our articles, either as retort or elaboration, you are invited to communicate via letter or Email. And if you have a workshop or a book experience to tout, rave or warn us about, the *RAQ* may play a role. Your contributions will make a difference. Email or write to WDVA.

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Efficacy of Grief Counseling, Critical Incident Debriefing Critiqued—*Studies contend some normal people don't grieve over the passing of a loved one and that grief counseling can do harm*

By EE

The headline in the January 20, 2004 *New Yorker*, page 30, "Annals of Medicine" article reads: "The Grief Industry: How much does crisis counseling help—or hurt?" The headline is a bit misleading, as the content of the article really is about critical incident debriefing and focuses on the examples from the New Yorkers involved in the 9/11 destruction of the World Trade Center. The piece is by Jerome Groopman, who is listed in the credits as "Recanati Professor of Medicine at Harvard and author of the just published book, *How People Prevail in the Face of Illness."*

Dr. Groopman depicts witnesses to the disaster as being sometimes tacitly forced by their employers to participate in debriefing sessions, and in some cases causing pathology by forcing them to focus on shared images, one survivor's experiences contaminating others. He writes, "I asked the (travel) agent whether he had chosen to attend the debriefing. 'Well, they felt everyone should participate,' he said."

Dr. Groopman observed that the motivation of company personnel directors may come from a compelling need to do something, and may also be caused by fear of litigation if the company did nothing. The author refers to a burn victim study in which the debriefed victims reported more PTSD symptoms than the control group which received no debriefing. "Scientific studies suggest that, after a catastrophic event, most people are resilient and will recover spontaneously over time. A small percentage of individuals do not rebound, however, and require extended psychological care. The single intervention of a debriefing session does nothing to alter this consistent dynamic" (p. 32).

Dr. Groopman quotes Brett Litz of the Boston VA: "In the wake of a catastrophe like September 11th,...victims should not be asked to disclose their personal feelings about the event. All that is needed is 'psychological first aid': victims should be taken to a safe place, given food and water, and provided with information about the status of friends and family. None of this, he added, requires the presence of a psychologist" (p. 32). The author quotes Rachel Yehuda of the Bronx VA as advocating that doctors check our cortisol level the way they check cholesterol, to get a reading on vulnerability to PTSD. He also quotes the brief treatment techniques of Edna Foa and cognitive behavioral therapy that may be used to "restore resilience" (p.35).

George Bonanno of Columbia University addresses this controversy in the January 2004 issue of the *American Psychologist* ["Loss, Trauma, and Human Resilience: Have We Underestimated the Human Capacity to Thrive After Extremely Aversive Events?" 59(1), 20-28]. He argues that our knowledge base about reaction to traumatic experiences comes from people who have experienced psychological problems and are treated for psychopathology, which has led to the view that resilience is rare.

Dr. Bonanno distinguishes resilience from recovery. "The term *recovery* connotes a trajectory in which normal functioning temporarily gives way to threshold or subthreshold psychopathology (...), usually for a period of at least several months, and then gradually returns to pre-event levels. Full recovery may be relatively rapid or may take as long as one or two years. By contrast, *resilience*, reflects the ability to maintain a stable equilibrium" (p. 20). He elaborates: "Resilience to loss or trauma, as conceived in this article, pertains to the ability of adults in otherwise normal circumstances who are exposed to an isolated and potentially highly disruptive event, such as the death of a close relation or a violent or life-threatening situation, to maintain relatively stable, healthy levels of psychological and physical functioning. A further distinction is that resilience is more than the simple absense of psychopathology. Recovering individuals often experience subthreshold symptoms levels. Resilient individuals, by contrast, may experience transient perturbations in normal functioning (e.g., several weeks of sporadic preoccupation or restless sleep) but generally exhibit a stable trajectory of healthy functioning across time, as well as the capacity for generative experiences and positive emotions..." (p. 20). Because of the failure of clinicians to make the distinction, Dr. Bonanno maintains, "clinical interventions with exposed indivdiuals are sometimes ineffective and even harmful."

The author discusses what he refers to as the "often contentious debate" regarding the appropriateness of psychological debriefing when genuinely resilient individuals are "undermined" by clinical intervention. He contends that "available empirical literature" suggests that "resilience to the unsettling effects of interpersonal loss is not rare but relatively common, does not appear to indicate pathology but rather healthy adjustment, and does not lead to delayed grief reactions" (p. 23). In his survey of the literature and citing his own research, Dr. Bonanno adds that "there is no empirical study that clearly demonstrated the existence of delayed grief." He contests the idea that the absense of grief is pathological or implies a pathological relationship had existed with the

(Continued on page 7, see *Debriefing.)*

Debriefing, continued from page 6.

deceased. He does acknowledge, however, that delayed PTSD has been established, although he contends it is infrequent.

The thrust of Dr. Bonanno's argument is that resilience takes various pathways in the face of potentially traumatizing experiences. Interestingly, he notes that some personality traits that contribute to resilience, may not be desirable under normal circumstances. The pathways to resilience that he cites, also are cited in literature regarding the attributes of general physical health and present a complex picture. Hardiness, for example, consists of three dimensions, according to the author: "being committed to finding meaningful purpose in life, the belief that one can influence one's surroundings and the outcome of events, and the belief that one can learn and grow from both positive and negative life experiences" (p. 25).

Another "pathway" to resilience cited by Dr. Bonanno, is what he terms "self-enhancement", which he notes might also be labeled as narcissism. And here he notes the interesting idea that what may be a problem for some in normal circumstances of an inflated valueing of oneself, may be an asset when the traumatic events occur.

The third "pathway" to resilience cited by Dr. Bonanno is "repressive coping," which again, he notes, is generally viewed as maladaptive, but in circumstances of traumatic events "the same tendencies also appear to foster adaptation to extreme adversity" (p. 26).

A fourth trait that seems to promote reilience in the face of trauma is what the author refers to as "positive emotion and laughter." "Research has shown that positive emotions can help reduce levels of distress following aversive events both by quieting or undoing negative emotion" (p. 26).

Comment

Dr. Bonanno urges research that examines "the full range of possible outcomes (to traumatic events and loss): simply put, dysfunction cannot be fully understood without a deeper understanding of health and resilience" (p. 26). His article raises a recurring problem in clinical practice of the "clinical skew." For example, we as clincians mainly see survivors of trauma who display psychological problems. Combat survivors, like many survivors of child abuse, have incurred repeated traumas over a prolonged period that wears down even the most resilient individuals. And the data is ambiguous, for we know that even self-enhancers and repressors have symptoms that result in, if not PTSD, problems that are contained in private.

While we concede that many people do not grieve loss and survive a traumatic event without pathology, we also see a nagging issue of collective denial of the magnitude of psychological problems arising from traumas such as war and child abuse. The cost of war is funded in the national Defense budget, but the long term cost of casualities that spread out over the lifetime of the veterans, and sometimes into future generations, is never calculated. What we see is not the collective denial that many people survive warfare without any maladaptation, but rather the opposite, the nation and its leaders failing to acknowledge that the psychological problems of the traumas of warfare pervade and contaminate our society long after the war has ended. I can admit to the clinical skew, but it angers me that psychological problems resulting from trauma are so often minimized or regarded as exceptional moral failures to adapt. ##

Phone numbers for WDVA and King County Veterans counselors and contractors are listed in alphabetical order.

Steve Akers, MSW, Everett…….…425 388 0281
Clark Ashworth, Ph.D., Colville……...509 684 3200
Wayne Ball, MSW, Chalan & Douglas…509 667 8828
Bridget Cantrell, Ph.D., Bellingham...…360 714 1525
Dan Comsia, MA, King County……..253 840 0116
Paul Daley, Ph.D., Port Angeles……...360 452 4345
Duane Dolliver, MS, Yakima...……509 966 7246
Jack Dutro, Ph.D., Aberdeen……..……360 537 9103
Emmett Early, Ph.D., Seattle……....206 527 4684
Dorothy Hanson, MA., Federal Way ...…253 841 3297
Tim Hermson, MS, Kennewick.……..509 783 9168
Bruce Harmon, M.Ed., Renton...…….….425 277 5616
Bill Johnson, MA, Mount Vernon……...306 419 3600
Dennis Jones, MA, Mount Vernon…..….360 419 3600
Bob Keller, MA, Olympia……360 754 4601
Frank Kokorowski, MSW, King Co VP..206 296 7565
Ron Lowell, King County Group…….425 308 8862
Bill Maier, MSW, Port Angeles, Sequim.360 457 0431
Brian Morgan, MS, Omak……....509 826 0117
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Dwight Randolph, MA, Seattle..…….….206 465 1051
Stephen Riggins, M.Ed., Seattle……..206 898 1990
Ellen Schwannecke, M.Ed., Ellensburg...509 925 9861
James Shoop, MS, Mount Vernon……360 419 3600
James Sullivan, Ph.D., Port Orchard...….360 876 2322
Darlene Tewault, MA., Centralia...…….360 330 2832
Tom Wear, Ph.D., Seattle…….……206 527 5382
Stephen Younker, Ed.D., Yakima.……...509 966 7246

WDVA PTSD Program Director:

Tom Schumacher……. ….……...…360 586 1076
Pager……...… 800 202 9854 or 360 456 9493
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To be considered for service by a WDVA or King County contractor, a veteran or veteran's family member must present a copy of the veteran's discharge form DD-214 that will be kept in the contractor's file as part of the case documentation. Occasionally, other documentation may be used prove the veteran's military service. You are encouraged to call Tom for additional information.

It is always preferred that the referring person telephone ahead to discuss the client's appropriateness and the availability of time on the counselor's calendar. Contractors are all on a strict and tight monthly budget, however, contractors in all areas of the state are willing to discuss treatment planning .

Some of the program contractors conduct both group and individual/family counseling. ##

PTSD Post-Hospital Deaths Examined, Mortality Rates Found to Continue from Early Reports

The lead article in the December *Journal of Traumatic Stress Studies* [2003, 16(6), 535-543] carries the title "Causes of Death Among Male Veterans Who Received Residential Treatment for PTSD." The authors, led by Kent Dresher of the National Center for PTSD at Menlo Park, investigated the reasons for the high reported death rate among former patients in PTSD inpatient programs. After reviewing a number of published studies reporting high rates of death from veterans who leave PTSD inpatient programs, the authors state their reason for investigating: "It is currently unclear whether high rates of deaths from external causes identified in the early studies of mortality among Vietnam veterans have continued. It is also unclear at present whether deaths expected to occur from increased stress-related health risks are becoming apparent among those veterans with chronic war-related PTSD as they age." (p. 536).

Prospective Study

Dresher, et al, followed 1,866 veterans from VA PTSD residential rehabilitation treatment programs between 1990 and 1998. Individuals with psychosis, active legal problems, or severe medical illness were excluded. Co-morbid diagnoses were prevalent: 81.2% also had depression, 67.2% had alcohol dependence, 49.9% had drug dependence histories, and 4.6% had a history of bipolar disorder. The authors compared what they termed 'behavioral deaths' with deaths from other disease processes. Behavioral causes of death were defined as deaths from high risk behaviors, including accidents and intentional deaths, and including deaths from alcohol liver cirrhosis and infections causes by IV drug use.

Of the 1,866 veterans followed in the study, for the 9 year period, 110 (5.9%) died, a figure higher than expected from a general population. The authors found that 62% of the deaths were from behavioral causes, one-third were from alcohol or drug use.

Graphic Comparisons

Drescher, et al, present an impressive bar graph on page 540, comparing "CDC expected deaths" to the PTSD graduates. The categories that leap out as exceptional are deaths caused by accidents, intentional deaths, and chronic substance use.

"These results suggest that the patterns in death rates for external causes seen in the early mortality studies of Vietnam veterans have continued for those veterans with severe PTSD seeking residential treatment" (pl. 541). The authors call for "enhanced clinical attention toward harm reduction strategies designed to reduce morbidity and mortality associated with behavioral causes. Current PTSD treatment programs focus heavily on the reduction of PTSD symptoms and their associated distress. Although this is appropriate for individuals suffering from acute PTSD, it is not sufficient to meet the clinical needs of individuals with more chronic and complex forms of PTSD. Many patients receiving residential PTSD treatment decades after the occurrence of traumatic events have multiple comorbidities and severe chronic life problems, combined with an isolated lifestyle with few resources and supports. The findings suggest that PTSD residential treatment programs could benefit from paying more attention to the current life-threats associated with substance abuse, hostility, violence, and depression" (p. 541).

"These results suggest that the patterns in death rates for external causes seen in the early mortality studies of Vietnam veterans have continued for those veterans with severe PTSD seeking residential treatment" (pl. 541).

Post-hospital Followup

In the era of VA budget belt tightening, the authors, noting the severe dysfunction in the sample population, recommend continuing care as follow-up. "Although this sample was drawn from patients discharging from residential treatment, the average time from discharge to death (among those...patients who died during the study period) was roughly 4 years. This highlights the strong need for continuing care for veterans with chronic PTSD that allows for effective transitions to and from programs of various degrees of intensity (i.e., inpatient, outpatient, and community-based programs)" (p. 542).

Comment

There are those who scoff and question the existence of PTSD. Many in our society prefer not to look at the long term costs of this disorder. The inpatient PTSD programs offered by the VA attract hard cases with comorbid disorders. Dresher, et al's sampling revealed 5.9% of the discharged patients were dead within nine years, the average surviving only four years. It is chilling to then extrapolate that number to include all the hard case veterans in the country. EE ##

Coping Styles & Influence of Mind on Health—

"Believing that control is out of one's hands has bad health consequences."

Vanderbilt psychologist Oakley Ray reviewed literature on physical health and psychology in the January *American Psychologist* ["How the Mind Hurts and Heals the Body," 2003, 59(1), 29-40]. He sets his thesis with an opening quote from John Milton's *Paradise Lost:* "The mind is its own place, and in itself/Can make a Heav'n of Hell, a Hell of Heav'n." Dr. Ray states what appears to be his position: "Our physiology and biochemistry are not separate and distinct from the rest of our life and our experiences. The mind—a manifest functioning of the brain—and the other body systems interact in ways critical for health, illness, and well-being" (p. 29). These symptoms he delineates as "four interacting information-processing systems in humans: the mind..., the endocrine system, the nervous system, and the immune system..." (p. 31). He reiterates three times a point that he appears adament about: "For my purposes, I consider the fourth system, the mind (psyche), as the functioning of the brain.... Our thoughts, our feelings, our beliefs, and our hopes are nothing more than chemical and electrical activity in the nerve cells of our brains. It is literally true that as experience changes our brains and thoughts, that is, changes our minds, we are changing our biology" (p. 32).

Dr. Ray uses the awkward word "allostasis" (elaborated by Dennis Charney on page 1, this *RAQ*). "Stress/allostatic load is experienced when there is an inadequate match between an individual's coping skills and the environmental demands that the individual believes these skills must confront. It is important to note that it is not the coping skills that individuals have or do not have that are important. What counts are the coping skills that individuals *believe* they have or do not have. Similarly, except for some obvious physical environmental situations—such as natural disasters—the important determiner of life demands is the perception of the situation" (p. 32, emphasis added).

Coping Skills

Dr. Ray states that "the balance between the individual's coping skills and the environmental demands determines psychological equilibrium or disequilibrium" (p. 32). He lists four classes or categories of coping skills: (1) *Knowledge*, which he breaks down as a measure of years of education, (2) "*Inner Resources,"* which "is a set of beliefs each of us acquires in the process of growing up. Inner resources are not facts—they are beliefs, assumptions, and predictions" (p. 33). (3) *Social Support*, which he states "refers to the interpersonal relationships that we have formed and nurture" (p. 33). (4) *Spirituality*. Referring to a study of men over 55 undergoing elective cardiac surgery: "Those who professed no strength or comfort from religion were three times as likely to die in this six-month period as those who said they drew strength and comfort from religion. Those who did not participate in group activities were four times more likely to die than those who did" (p. 33).

Dr. Ray quotes research showing administration of rhinoviruses to experimental subjects infected those with high stress scores in an almost linear fashion—the higher the stress score on the subject, the higher the rate of infection. He also referred to the survival statistics for women with breast cancer. "Of major importance was the finding that at the 5-, 10-, and 15-year follow-ups, the best single predictor of death (from any cause, including breast cancer) or recurrence of cancer was the psychological response of each woman three months after surgery. Her mental attitude three months after surgery better predicted the likelihood of dying or having a recurrence of cancer than did the size of her tumor, the tumor's histologic grade, or her age. The 15-year follow-up results are straightforward: Women who showed fighting spirit ('I'm going to beat this,') or denial ("I never had cancer, the doctor took off my breast as a precaution,') had a 50% chance of surviving 15 years in good health. Women with the other three attitudes (stoic acceptance, hopelessness, anxious preoccupation) had about a 15% chance of surviving 15 years" (p. 35).

Social Support

Of interest to introverts is Dr. Ray's evidence for the benefit of social support. He quotes David Spiegel's assertion that "the strength of this relationship [between social support and mortality] is as great as that between high serum cholesterol and mortality or between smoking and mortality" (p. 36). Dr. Ray endorsed psychotherapy as a way of gaining the benefits of social support. He refers to a study at Stanford led by Dr. Spiegel in which women receiving chemotherapy for breast cancer were given psychotherapy. "One year of weekly 90-minute group therapy session for these women almost doubled their survival time" (p. 36).

Dr. Ray puzzles about interpretation of the positive benefits of social support. Unfortunately, he does not consider the possibility that healthier people have more social support because they are attracted to each other.

The author concludes his discussion by addressing the issue of will to live and irrational beliefs in fate, which he contends is a major effect. "Believing that control is out of one's hands leads to bad health consequences" (p. 38). He noted interesting studies in which people tend to die significantly more often after important holidays in which they play a role, rather than the same time period before such holidays.

Such discussions draw attention to the PTSD symptoms involving avoidance of social involvement and having a sense of foreshortened future and their long term effects on health.

EE ##

Adaptation, Continued from page 1.

Dr. Charney then proceeds to discuss resilience in children and adults in a more behavioral light. "Studies of children raised in a variety of settings, including war, family violence, poverty, and natural disasters, have revealed a consistent pattern of individual characteristics associated with successful adaptation. These include good intellectual functioning, effective self-regulation of emotions and attachment behaviors, a positive self-concept, optimism, altruism, a capacity to convert traumatic helplessness into learned helpfulness, and an active coping style in confronting a stressor..." (pp. 203-4). Adult adaptation is characterized by "an ability to bond with a group with a common mission, a high value placed on altruism, and the capacity to tolerate high levels of fear and still perform effectively" (p. 204).

Dr. Charney elaborates on successful adaptation to fear and anxiety. "Fear conditioning in many patients with PTSD and major depression causes vivid recall of memories of traumatic events, autonomic hyperarousal, and even flashbacks elicted by sensory and cognitive stimuli associated with prior traumas. Consequently, patients may begin to avoid these stimuli in their everyday lives, or a numbing of general emotional responsiveness may ensue. Resilience to the effects of severe stress may be characterized by the capacity to avoid overgeneralizing specific conditioned stimuli to a larger context, reversible storage of emotional memories, and facilitated extinction" (p. 205).

Dr. Charney's article grows weaker when he deals with the neural basis of social behavior, such as altruism and social cooperation, indicating that this is an area for further research. He expresses optimism for the uses of neuro-imaging technology, which promise to lead to new treatments for PTSD. He notes, however, that "an investigation of twin pairs from the Vietnam Twin Registry...reported that inherited factors accounted for up to 32% of the variance of PTSD symptoms beyond the contribution of trauma severity" (p. 210).

Comment

This state-of-the-art article gives the neuro-anatomical basis for the behaviors we treat in psychotherapy. Such research leads to new pharmaco-therapies, in addition to psychotherapy. One of the difficulties that psychotherapists have with psychiatric medications, especially with older clients, is the sheer number of pills they end up taking. While each pill may be perfectly justified, when massed together they become a symbol of pathology for a person who has to take handfulls of pills several times a day. Clients who are dealing with diabetes, hypertension, gout, gurd, arthritis, liver disease, headaches, sleep disturbance, anxiety, depression, intrusive thoughts, and etc, take so many pills that they are depressed by the every day reminder of their burden. The risks of medication interactions go up as the number of pills increase, leaving the client with an unpredictable iatrogenic load prescribed to cope with his allostatic load.

The term "allostatic load" suggests the reality that PTSD is a problem involving a number of neurological and therefore behavioral systems. The long term management of these systems that have got off track requires a strategy at least as complex as the problem. Studies of resilience, for our purposes, are like examining the feed supply after the cows have gone mad. Resilience, as a concept, seems almost platitudinous, unless the discussion can lead to changes in the selection of those who are placed into combat. It does, however, give us some appreciation regarding the likelihood of someone sustaining employment or enduring relationships in the face of ongoing stress. ##

Movie Review:

American Splendor--VA Hospital File Clerk is Cartoon Success

There are several endearing facets of *American Splendor*, and I am not a fan of animation or a comic book collector. Harvey Pekar (Paul Giamatti) is a file clerk at the VA hospital in Cleveland. His co-workers are all strange savants who have their talents. The scenes in the file room are a mix of competence and quirkiness. Not where this viewer would trust his important papers.

Harvey is a kind of schizoid wiseguy and his unique wit befriends him to comic book artist Robert Crumb (James Urbaniak). Harvey complains about comic books not reflecting real life and decides to write his own. He fills in the content of the bubbles and Crumb draws him and his friends and VA co-workers. Our movie then takes on another dimension. Cartoon characters inject their commentary and real Harvey appears playing himself.

American Splendor was directed by Shari Springer Berman and Robert Pulcini, who had a hand in the writing, along with Harvey Pekar and Joyce Brabner. Harvey falls awkwardly in love with Joyce (played by Hope Davis) and their relationship, of course, is drawn into the comic book.

American Splendor is presented as a real life comic book success. Several other artists draw Harvey's character as he goes through a real life cancer scare. We come to love his weaknesses and his courage. The world of comic books is a subculture, like motorcycles and guns. Not for everybody and with a range of weirdness that is also not unlike a clinical faculty and staff. Imagine the therapist coming home from a hard day...fill in the bubble. EE ##

Movie Reviews:

For Some War Veterans Fighting Continues at Home

By Emmett Early

Cold Mountain

Anthony Minghella directed the long awaited film version of Charles Frazier's *Cold Mountain*, which featured a Civil War veteran's archetypal odyssey home from the battlefield. The movie opens just before war breaks out. Young Inman (as he is called) meets the new minister's daughter, Ada (Nicole Kidman). The minister is played by an aged Donald Southerland. We get a sense of Inman (Jude Law) as a shy lad who Ada has to approach for conversation.

Then there is the war. Young men parade through the streets with enthusiasm, most of whom will never return. We next see Inman aged and worn as a veteran of combat about to participate in the carnage at the Battle of the Crater, Petersberg, where the word 'undermining' took new meaning. He survives the explosions and carnage, wounded in the neck, and escapes from the hospital on the Georgia coast, beginning his trek home to the Blue Ridge Mountains, following his desire to reunite with Ada.

Ada, meanwhile, in interspersed scenes, sees her fortunes decline after losing her father. She is ill-prepared to maintain a farm without help. The inhabitants of Cold Mountain are going through the upheaval of war, with poverty, the loss of their men, and the marauding Home Guard, who root out deserters and kill them.

On his odyssey, Inman meets a host of symbolic characters, the randy preacher (Phillip Seymore Hoffman), porcine sisters of pleasure, the forlorn ferry girl, a chain gang, the reclusive goat lady who nurses his wounds, and the widow woman who he protects from rape and loneliness. And in the end he finds his Ada.

In the meantime, Ada has been saved by the salt-of-the-earth Ruby (Reneé Zellweger), who revives the farm and connects with her own abandoning father, the wandering fiddler (Brendon Gleeson, who almost steals the show).

The comparison to Homer's *Odyssey* is in the successive trials that variously attack the veteran and impede and prolong his return. They describe in an abstract way the post war social alienation experienced by combat veterans and close support personnel who must integrate the destruction and regression to primitive values that accompany warfare.

Inman finally succeeds in a Darwinian sense. He successfully reunites with Ada long enough to propagate, but beyond that his quality of life diminishes like a spawning salmon.

Perhaps Nicole Kidman's Ada is too comely for the role, and perhaps Jude Law's Inman is too remote to inspire us, but the power of attraction for the film is the culture of the country in Cold Mountain as the musicians give us their inspired playing, making it something to return to. Overall, Frazier's wonderfully gripping story comes across.

The Dawning

In the 1988 British film, *The Dawning*, Rebecca Pigeon plays Nancy, a girl just turned 18, whose mother died giving birth to her, and whose father abandoned her shortly thereafter. She was raised by her Aunt Mary (Jean Simmons) in a middle class Irish coastal house. Nancy is a blushingly innocent but hardy girl who has just finished her schooling and is shortly to go off to Trinity College in Dublin. It is 1920 and her inexperience with eligible men is the source of her infatuation with an incredibly improbable war veteran, Harry, played by Hugh Grant. Harry is an unimaginative, conservative man who is himself almost oblivious of Nancy and infatuated with a neighboring girl.

Nancy has taken over a beach shack for her private musings. She keeps a little bed there, along with books and candles. One day an IRA gunman (Anthony Hopkins) appears. The movie begins with him being put ashore in a small boat. He knows of the beach shack because he grew up in the area. He too is a WWI veteran, but as he says, his war continues. He is a stranger who comes to intrigue Nancy. He is old enough to be her father, and when he refuses to give her his name, she romanticizes that he could indeed be her father. She calls him Cassius and her Aunt Mary later identifies him from his picture as Angus, the son of landed gentry whose fortunes had declined.

Also a war veteran is Nancy's grandfather, "The General," (Trevor Howard), who fought in the Crimean War, and who now sits in a wheel chair and looks out with his binoculars, apparently, from his halting speech, the victim of stroke.

Directed by Robert Knights, *The Dawning* was adapted to the screen by Moira Williams from a novel, *The Old Jest*, by Jennifer Johnston and released in 1988. It is a well-crafted romance and is carried competently by the cast of Pigeon, Hopkins, and Simmons. The Irishness is treated as Republican and the Irish are anglicized: the lower the class, the more Irish. Their housekeeper, Bridy (Ronnie Masterson) is a Republican.

There is a sprightliness to Pigeon's Nancy. Her father, who abandoned her, is perhaps the Irish assassin. Hugh Grant's Harry isn't very Irish either. Hopkins' disillusioned veteran is more convincing. The total absence of sexuality is odd, because the potential is there in the plot, and certainly there is an undercurrent, when Nancy witnesses IRA assassinations at the holiday races and is then courted by one of the local young terrorists.

Like *In Country*

Contrast *The Dawning* with *In Country* and 18-year-old Sam's quest to identify her father through contact with evasive, avoidant Vietnam War veterans, including her uncle. Both girls are 18 and just finishing school. *In Country's* Sam is the more sophisticated, while Nancy is caught up in another war **(Continued on page 12, see *Movies*.)**

***Movies*, continued from page 11.**

that is poorly understood and not explained. Sam, like Ada in *Cold Mountain* and Nancy, seeks to right herself after her father's death.

Anthony Hopkin's Angus is a tragic figure, a war veteran who is unapologetic about continuing the fight. He dies in a way that seems predestined, shot down in the surf in retaliation for the IRA assassinations of British army officers at the race track.

Inman in *Cold Mountain* shares traits that are similar to Angus. They are both at odds with their society. Inman has to fight and connive to make it home in a society disrupted by war. It seems that there is no authority to protect him as he seeks to return to his birthplace. Angus, now an IRA assassin, hides in a driftwood cabin on a rocky beach only to be found by a girl who lost her father.

Angus is a veteran of the British trenches in WWI. He too finds his homeland inhospitable. His land is occupied by a foreign power and he feels compelled to use his military skills, developed on the battlefield, to continue fighting. At one point in their conversation, as Nancy begins to idealize him, he takes out his pistol and displays it, so that she knows who she is dealing with. His gesture at first repulses her, but she is drawn back when she compared his dedication to her dull, Anglo-Irish middle class life.

Symbols of Alienation

Both movies dramatize the war veterans' alienation with real antagonists in post war life, but the mundane daily adjustment for those with chronic PTSD has the same abstract components. One of the consequences of chronic PTSD is its very chronicity, which results in an accumulation of deficits and coping habits.

Both Inman and Angus must hide from unjust authority occupying their lands. The feminine connection is different. Ada and Inman propagate literally, while Angus inspires Nancy with the spirit of independence and rebellion. The woman, or girl, in any case is changed forever by her experience with the veteran, who survived as long as he could. Each war veteran is eventually shot down like an unwanted animal.

The fact that mythology parallels the war veterans through differing cultures and eras is a statement about the universality of the experience. It is important, however, not to lose sight of the personal experience where myth is concealed in the symbolism. As was noted in the last issue of the *RAQ,* sometimes monsters are real. Superlative statements from braggarts aside, the feelings of the veteran make the connection to the archetype. To *feel* trapped, compelled to fight on foreign fields, can obsess the veteran who is merely leaving his house to drive to an appointment. The feeling is not a constant, but can appear suddenly as surprise.

The drive to survive is a road full of ambushes and traps. In the real life post war world, the ambushes and threats may be as common as the spouse entering a room unexpectedly and startling the veteran, who must spend the rest of his day getting unstarted. Or the ambushing enemy may be the DUI judge, who means well, but who sentences the veteran to serve time in the alcohol treatment program rather than addressing the PTSD.

The parallels to combat can compel a veteran to add to a contemporary problem, the vehement emotion of life or death. For example, the experience of being trapped and surprised by a court order may have the emotional connection of combat, but to fight or flee as though one were being shot at, would be to overreact and add to the problem. To be held back on one's job, prevented from effective work, may have an historic ring, but to give it life and death fervor, would be to obfuscate rather than clarify the situation.

Many observers, including Carl Jung, have recommended that clinicians look at dreams when the opportunity presented, because dreams can give us both the archetypal and the personal historical connection. When, in the process of relating a dream, the client associates to a memory, even if the memory seems tangential, it deepens the meaning, and when the dream and the memory are related to present events and feelings, new dimensions appear.

War veterans Angus, hiding in the driftwood cabin, and Inman, trekking on the hostile road home, are enacting what the war veteran with PTSD feels. And he feels what Odysseus must have felt have felt when he was washed ashore on Pheaecia, battered and stripped of all his possessions, kneeling in the stream before Nausicaa, praising her and asking for her help in his turbulent journey home from the war. ##

The Repetition & Avoidance Quarterly **is published each season of the year by The Washington Veterans PTSD Program, of the Washington Department of Veterans Affairs. The PTSD program's director is Tom Schumacher. The editor of the *RAQ* is Emmett Early. It is intended as a contractors' newsletter for the communication of information relevant to the treatment of PTSD in war veterans and their families. Your written or graphic contribution to the PTSD Program newsletter is welcomed if it is signed, civilized, and related to our favorite topics of PTSD and war veterans. Contributions may be sent by mail to the Washington Department of Veterans Affairs (Attn: Tom Schumacher), PO Box 41150, Olympia, WA 98504, or by Email directly to <emmett@dva.wa.gov>. Readers are also invited to send in topical research or theoretical articles for the editorial staff to review. Comments on items reported in the *RAQ* are also encouraged and will likely be published if they are signed. To be included in our mailing list, contact WDVA, Tom Schumacher, or Emmett Early. The *RAQ* can also be read online by going to www.dva.wa.gov Once in the WDVA Website, click on PTSD, and once on the PTSD page, scroll to where you find access to the *RAQ*. The newsletter logo is a computerized drawing of a photograph of a discarded sign, circa 1980, found in a dump outside the La Push Ocean Park Resort. ##**